Patient Name: _____

Date of Birth: _____ SS# _____

If minor/child who is head of the acct?:_____

College Student? Name of school: _____

DENTAL HISTORY (Please circle your answer).

1. Why are you here today? Emergency? Yes No
   Initial (first) Exam? Yes No
   Periodic Exam Yes No
   Consultation/2nd opinion? Yes No

2. Do you have a specific dental concern today? Explain ----->
3. How long has it been since you have last been to a dentist?
   ____ months? _____ years?
4. Do you usually make routine visits for check ups? Yes No
5. When were your last xrays taken?? _____
6. Have any of your teeth been removed/extracted? Yes No
   If yes, have they been replaced? (with denture? partial? bridge?)
7. Have you ever had any unusual complications with dental treatment? __ Yes __No Please explain ------->
8. Does food get stuck between your teeth? Yes No
9. Are you aware that you clench or grind your teeth? Yes No
10. Does your jaw ever ... Hurt? Click? Snap? Yes No
11. Do you have sensitive teeth? Yes No
    Hot? [ ] Cold? [ ] Brushing? [ ] Sweets ? [ ] Chewing? [ ]

13. Do your gums ever bleed or hurt? Yes No
14. Have you ever been treated for gum disease? Yes No
    Please explain ---------->
15. Are your aware of any broken or chipped teeth? Yes No
    Please explain ---------->
16. Are you happy or unhappy with the looks of your teeth?
    What would you change? Please explain --------->
17. Do you feel your breath is offensive? Yes No
18. Have you ever had braces (orthodontics)? Yes No
19. Have you ever had an unpleasant dental visit? Yes No
20. Are you taking medication for bone density? Yes No

LIST ALL MEDICATIONS BELOW: ***(or indicate what the medications are for if unsure of the spelling)***
Include herbal supplements and over the counter meds

Medication	For

Use this space to explain your answers)

MEDICAL HISTORY: (Please circle your answer)

1. Physician's Name: _____

Name of Medical Clinic or Location _____

2. Are you presently under a physician's care? Yes No
If yes, please explain in the comments section —------->

3. Are you using any medications or substances? Yes No
If yes, please explain in the comments section —------->

4. Do you have any allergies to:
Local Anesthetics? Yes No
Penicillin? Yes No
Other antibiotics? Yes No
Latex (rubber gloves, tape? etc.) Yes No
Codeine? Yes No
Narcotics? Yes No
Other medications? Yes No
If yes, please explain in the comments section —------->

5. Are you sensitive to any metals? Yes No
If yes, please explain in the comments section —------->

6. Are you pregnant? (Due date: _____) Yes No

7. Do you use any birth control medications? Yes No
(*Some medications used can react with these)

8. Do you have heart problems? Heart attack? Stroke?
Pacemaker? Heart Murmur? Please explain: Yes No

9. Do you have high or low blood pressure? Yes No
If yes, please explain in the comments section -------->

10. Do you have any artificial joints or prosthetics? Yes No
If yes, please explain in the comments section ---------->

11. Do you have blood disorders (anemia, leukemia) Yes No
If yes, please explain in the comments section --------—->

12. Do you bleed easily after being cut or injured? Yes No
If yes, please explain in the comments section --------—->

13. Have you ever had a serious injury or surgery? Yes No
If yes, please explain in the comments section —--------->

14. Are you having stomach problems? Yes No
If yes, please explain in the comments section --------—->

15. Are you having liver problems? Yes No
If yes, please explain in the comments section --------—->

16. Are you having kidney problems? Yes No
If yes, please explain in the comments section --------—->

17. Are you diabetic? Yes No
If yes, do you use insulin? Yes No

18. Do you have asthma? Yes No

19. Do you have epilepsy? Yes No

20. Do you have AIDS? Yes No

21. Are you HIV positive? Yes No

22. Do you or have you had hepatitis? Yes No

23. Do you have thyroid problems? Yes No

24. Do you or have you ever had a venereal disease? Yes No

25. Do you have glaucoma? Eye conditions? Yes No

26. Do you or have you had TB (tuberculosis) Yes No

27. Do you smoke, use snuff, or chew tobacco? Yes No

28. Are you chemically dependent? __ Yes __ No
Drugs? _____ Alcohol? _____

29. Any other medical concerns? ____ Yes *See Comments

Please list for us:

EMERGENCY CONTACT: _____

PHONE: _____

I hereby certify that the information I provided is complete, accurate and true. I understand this health information is necessary for the dentist's professional consideration in providing me with safe dental care and treatment. I also understand that any information I provide is protected by the HIPAA privacy protection mandates and is kept confidential.

Patient/Parent Signature: _____

Date signed: _____

Dentist's Signature: _____

Date signed: _____